BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

SAMARA K. SALAS	)	
Claimant	)	
	)	
VS.	)	
	)	
BEEF PRODUCTS, INC.[1]	)	
Respondent	)	Docket No. **1,048,470**
	)	
AND	)	
	)	
LIBERTY INSURANCE CORP.	)	
Insurance Carrier	)	

ORDER

Respondent and its insurance carrier (respondent) request review of the October 15, 2012, Award by Administrative Law Judge (ALJ) Pamela J. Fuller. The Board heard oral argument on March 6, 2013.

APPEARANCES

Bruce A. Brumley of Topeka, Kansas, appeared for claimant. William L. Townsley of Wichita, Kansas, appeared for respondent and its insurance carrier (respondent).

RECORD AND STIPULATIONS

The Board has considered the entire record and adopts the stipulations listed in the Award.

ISSUES

The ALJ found claimant sustained a 5% whole body permanent functional impairment. Work disability benefits were awarded for several periods based on the varying levels of claimant's post-injury earnings. Claimant eventually stopped earning any

[1] A number of the deposition transcripts, along with a written stipulation regarding claimant's post-injury wages, list the respondent as "Tyson Fresh Meats, Inc." In a written stipulation approved by both counsel and filed on August 27, 2012, the parties agreed that all such typographical errors should be corrected to list Beef Products, Inc., as the respondent.

wages, at which point the ALJ found claimant's work disability was 50% based on claimant's 100% wage loss. The ALJ found no task loss.

Respondent raises the issue of the nature and extent of claimant's disability. Specifically, respondent claims the ALJ erred in awarding any permanent partial disability (PPD) benefits because claimant did not prove she sustained a permanent injury and because claimant did not prove a permanent functional impairment or work disability resulted from the accident.[2]

In her brief, claimant raises the following issues: (1) whether claimant's injury arose out of and in the course of her employment; (2) the nature and extent of her disability; (3) future medical treatment; and, (4) approval of attorney fees for claimant's counsel.

The issues presented to the Board are:

1. Did claimant's injury arise out of and in the course of her employment with respondent?

2. What is the nature and extent of claimant's disability, including:

a) Did permanent injury result from the accident?

b) Did claimant prove she sustained a permanent impairment of function as a result of the accident?

c) Is claimant entitled to work disability benefits and, if so, to what extent?

3. Whether claimant's counsel is entitled to attorneys fees.

4. Whether claimant is entitled to future medical treatment.

Since the alleged accidental injury occurred before May 15, 2011, the "Old Act" applies to this claim.[3]

[2] Respondent does not dispute that claimant sustained an accident working for respondent when she slipped and fell on April 15, 2009. Respondent's Brief at 16 (filed Dec. 10, 2012).

[3] See K.S.A. 2008 Supp. 44-505(c); *Bryant v. Midwest Staff Solutions, Inc.*, 292 Kan. 585, 257 P.3d 255 (2011).

FINDINGS OF FACT

Having reviewed the entire evidentiary record, the stipulations of the parties, and having considered the parties' briefs and oral arguments, the Board makes the following findings:

Respondent hired claimant on February 2, 2009, as a quality assurance inspector. Claimant's job required her to extract "core samples" of respondent's products. The core samples were placed in a bucket and it was claimant's duty to take the samples to be tested. Taking the core samples for testing required claimant to descend a few steps.

Claimant, who was age 25 when the April 15, 2009, accident occurred, testified:

> As soon as I finished coring the product, they set it into a sample bucket so I could walk it down a couple of steps to go test it. And when I was walking down, I slipped and fell and I fell on my bottom and hit my lower back while I was holding the rail.[4]

Claimant testified that she was gripping the railing with her left hand and did not let go of it, despite the slip and fall.[5] The accident happened around 11 p.m. Claimant experienced a burning sensation in the middle of her back which she testified was 2 to 4 on a 10 point pain scale.[6] Claimant reported the accident to respondent and saw the plant nurse.[7] Claimant was sent home by respondent before her shift ended.

Claimant testified that the following morning, April 16, 2009, she had increased pain which she described as a shocking feeling in her left upper back and mid-back. She rated her pain on November 16, 2009, at "Maybe seven to nine."[8] Claimant had no treatment whatsoever between May 12, 2009, (when she saw a plant nurse employed by respondent) and her return to the plant nurse on October 16, 2009. Claimant did not see a physician from April 15, 2009, until November 4, 2009. Claimant's delay in seeking treatment was because she did not know she could seek treatment. Claimant did not seek treatment on her own.

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[4] R.H. Trans. at 11.

[5] *Id*. at 26.

[6] *Id*. at 25, 27.

[7] This plant nurse was employed by Tyson. Respondent had no plant nurse at the time of the accident. Tyson and respondent are located on the same premises.

[8] R.H. Trans. at 27.

Claimant's employment with respondent ended on May 12, 2009. The evidence is conflicting with regard to whether claimant quit or was terminated.[9]

Claimant testified at her February 6, 2012, deposition and at the June 4, 2012, regular hearing that her only gainful employment since she stopped working for respondent was: 1) Target, for about a month in August 2009, and 2) Area Mental Health, from November 2010 to March 2011.[10] However, when claimant was cross-examined at the regular hearing, she eventually admitted she worked at Tyson as a butt boner after her employment at respondent ended.[11]

The parties thereafter entered into a written stipulation, filed on August 6, 2012, which details claimant's post-injury employment and wages earned. The information from that stipulation is accurately set forth in the ALJ's award and it would serve no purpose to duplicate it here.

On November 4, 2009, claimant initiated authorized treatment with Terry R. Hunsberger, D.O., who prescribed physical therapy and ordered diagnostic testing. X-rays, an MRI of the left shoulder and a total body bone scan were conducted and were all negative. Dr. Hunsberger's diagnosis was pain in the thoracic spine. He released claimant from his care without restrictions on February 22, 2010.

Dr. Pedro Murati examined and evaluated claimant on May 18, 2010, at the request of claimant's attorney. The doctor took a history and performed a physical examination. Claimant complained of pain near the left shoulder blade. As quoted in Dr. Murati's May 18, 2010, report, claimant also told the doctor:

1. "I can't do chores around the house due to my back pain."

2. "I have to sleep on my right side due to my back pain."

3. "I will never be capable of working the same job again due to my back pain."

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[9] *Id.* at 15, 44-45.

[10] The parties stipulated claimant's discovery deposition should be considered evidence for purposes of the final award. R.H. Trans. at 10; Salas Depo. at 18, 23, 56-58; R.H. Trans. at 20-21; Solorzano Depo. at 22-23, 34-35.

[11] R.H. Trans. at 33-34.

4. I have trouble lifting things, especially my daughter."[12]

It does not appear that Dr. Murati reviewed any medical records or reports before or after his examination. Nor does it appear Dr. Murati had any radiographic studies performed as a part of his evaluation. Dr. Murati reviewed none of the films or reports of the diagnostic testing claimant underwent. By the time Dr. Murati was deposed on May 14, 2012, it had been almost two years since he examined Ms. Salas. Dr. Murati diagnosed claimant as having a thoracic spine sprain which was secondary to her work injury.

Based on the AMA *Guides*[13], Dr. Murati found claimant fell into the AMA *Guides*' DRE Thoracolumbar Category II which provides for a 5% permanent impairment to the whole body. However, Dr. Murati did not explain, in his narrative report or in his testimony, the basis for his conclusion claimant fell within Category II.

Dr. Murati found claimant had reached maximum medical improvement (MMI). The doctor imposed these permanent restrictions based on an 8-hour day: (1) no lifting, carrying, pushing or pulling greater than 35 pounds occasionally, 20 pounds frequently and 10 pounds constantly; (2) no work more than 18 inches away from body; (3) no work above shoulder level; and, (4) no twisting at the trunk.

Dr. Murati reviewed the list of claimant's former work tasks prepared by Dr. Robert Barnett and concluded claimant could no longer perform 31 of the 37 tasks for an 84% task loss. Dr. Murati reviewed Dr. Barnett's amended report and concluded claimant's task loss was 68%. These additional reports were stipulated into evidence pursuant to written stipulation approved by both counsel and filed of record on August 27, 2012.

Dr. Robert Barnett, a clinical psychologist and vocational consultant, conducted a telephone interview with claimant on October 1, 2010, at the request of claimant's attorney. Dr. Barnett prepared a task list of 37 non-duplicated work tasks claimant performed in the 15-year period before her injury. Dr. Barnett, following his receipt of additional information, prepared an amended report.

Dr. Pat Do, a board certified orthopedic surgeon, examined and evaluated claimant on March 3, 2011, at the request of respondent. The doctor took a history, reviewed medical records, and performed a physical examination. Claimant told Dr. Do that "she

[12] Murati Depo., Ex. 2 at 1.

[13] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the AMA *Guides* unless otherwise noted.

went to the emergency room in May for pain medications."[14] Dr. Do found claimant had tenderness in the left paraspinal muscles and the thoracic spine. Dr. Do diagnosed claimant with a thoracic sprain/strain and recommended additional x-rays and MRI scans of claimant's thoracic and lumbar spine. Dr. Do also prescribed trigger point injections, an anti-inflammatory and muscle relaxant medication. Dr. Do imposed temporary work restrictions of no lifting greater than 30 pounds. However, Dr. Do allowed lifting 20-30 pounds occasionally and 0-20 pounds frequently. Dr. Do was apparently authorized to treat claimant.

The MRI scan of claimant's lumbar spine showed possibilities of post-laminectomy changes at L4-5, but claimant denied a history of lumbar surgery. There was some indication of high grade central canal lateral recess stenosis at L3-4. Claimant did not have any lower extremity symptoms and her physical examination was negative for any neurological compromise. The thoracic MRI was "[u]nremarkable."[15]

Dr. Do performed a second evaluation on August 8, 2011. Physical examination revealed midline thoracic tenderness. Dr. Do diagnosed claimant with myofascial thoracic pain, but no evidence of nerve compression or mechanical issues. The doctor opined that claimant's complaints were related to her accidental injury occurring on April 15, 2009. Dr. Do concluded claimant had achieved MMI.

Based on the AMA *Guides*, Dr. Do provided a 5% rating (DRE Thoracolumbar Category II) "for myofascial type issues."[16] Dr. Do, on cross-examination, admitted his rating was based on the fact claimant complained of pain from something that happened two years before. Dr. Do could not specify any objective findings that related to claimant's accident in April 2009. Dr. Do imposed no permanent restrictions.[17] Dr. Do reviewed the list of claimant's former work tasks prepared by Dr. Robert Barnett and concluded claimant could perform all of the 37 tasks for a 0% task loss.

Danny Briggs, Jr., a certified physician's assistant and an employee of Occupational Health Services (OHS), examined and evaluated claimant on April 11, 2011, at the request of respondent's attorney. Following claimant's initial examination by Dr. Do on March 3, 2011, Dr. Do evidently recommended claimant see Mr. Briggs for trigger point injections,

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[14] The Board can find nothing in the record documenting any ER visit.

[15] McMaster Depo., Ex. 2 at 3.

[16] Do Depo., Ex. 2 at 2.

[17] *Id*. at 23.

anti-inflammatory and muscle relaxant medicines. Mr. Briggs prescribed Soma, a muscle relaxant, and an anti-inflammatory, Relafen.

Mr. Briggs testified:

> Q. And what was the significance of your finding that she had a diffuse myofascial pain as opposed to trigger point symptomatology?
>
> A. I'm thinking in the -- in the exam part, and I'm just recalling this from memory, but she -- the pain was what I considered diffuse. It was over a large area, it wasn't just a specific place to where you could say she were [sic] having point -- trigger points, to where you could specify, you know, an injection here, an injection there to get rid of a trigger point type pain. It was diffusely over that scapular area and in the trap muscle itself.[18]

On April 28, 2011, claimant returned for follow-up with Mr. Briggs. Claimant's pain in the thoracic spine and trapezius muscle had resolved. Mr. Briggs released claimant without restrictions but recommended a return visit in two weeks. When claimant returned on May 12, 2011, she had increased pain, which prompted Mr. Briggs to recommend trigger point injections.

On May 26, 2011, claimant returned to see Mr. Briggs. Claimant indicated that she received no relief from the trigger point injections. Upon physical examination, Mr. Briggs found that claimant had severe pain with light palpations throughout the left scapular and thoracic spine. Mr. Briggs determined claimant had reached MMI and that she could return to work without restrictions.

On June 13, 2011, claimant returned to see Mr. Briggs for the final time. Upon physical examination, claimant did not have any signs of pain with palpation throughout the thoracic spine or the scapula and trapezius areas. Claimant had full range of motion in her cervical spine and left upper extremity without pain. Mr. Briggs referred claimant back to Dr. Do.

In his June 13, 2011 progress note, Mr. Briggs observed as follows:

> Patient is sitting in a chair in no acute distress. She moves back and forth from side to side in the chair without any pain or abnormalities. She reaches to the floor to pick up a magazine that she dropped without any pain. She ambulates without any signs of distress or discomfort. She rises from the chair and gets on the examination table with no signs of discomfort. She has no grimacing or signs of

[18] Briggs Depo. at 10-11.

> pain with palpation throughout the thoracic spine or to the left scapula area or throughout the paraspinals or upper trapezius. There is no muscle rigidity noted throughout these areas. There is full range of motion of the cervical spine and left upper extremity with no pain. On questioning the patient does not seem to be having any pain.[19]

Mr. Briggs' June 13, 2011, progress note also indicates "I think that she [claimant] is exacerbating her symptoms and not being fully honest with her complaints of 9 out of 10 pain."[20]

Steve Benjamin, a vocational consultant, conducted a personal interview with claimant on July 17, 2012, at the request of respondent's attorney. He prepared a task list of 49 non-duplicated work tasks claimant performed in the 15-year period before her accidental injury.

Dr. John McMaster, a physician board certified in family, emergency and hyperbaric medicine, examined and evaluated claimant on July 19, 2012, at the request of respondent's attorney. The doctor reviewed claimant's medical records, took a history and performed a physical examination.

Dr. McMaster found claimant did not have any significant impairment to her back or neck. He diagnosed claimant with transient, nonspecific, non-differentiated soft tissue pain in the left scapular and mid back regions. Dr. McMaster did not find any scientific or medical evidence to prove claimant suffered an injury as a result of her accident on April 15, 2009. Dr. McMaster rated claimant's impairment using the AMA *Guides* and found claimant sustained a 0% permanent functional impairment. Dr. McMaster opined claimant was at MMI and that no permanent restrictions were needed.

Dr. McMaster reviewed the list of claimant's former work tasks prepared by Steve Benjamin and concluded claimant could perform all of the 49 tasks for a 0% task loss.

Claimant testified, more than three years after the alleged injury, that none of the treatment she has received–including physical therapy, medications, trigger point injections, and light duty restrictions–changed the level of pain she experienced on the day after her fall.[21]

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[19] *Id.*, Ex. 1 at 8.

[20] *Ibid.*

[21] R.H. Trans. at 40; Claimant's Depo. at 64-69.

The parties entered into a written stipulation, filed on September 26, 2012, agreeing to the admission of employment records from Tyson Fresh Meats, Inc. The records indicate claimant worked for Tyson from April 13, 2010, to August 10, 2010. Tyson fired claimant for misrepresentations on the medical history questionnaire completed by claimant when she was hired. The last day claimant actually worked for Tyson was July 9, 2010, when Tyson laid claimant off and investigated the alleged misrepresentations.

The Tyson records contain a quantity of surplusage lacking any relevance to this claim. The records contain a document entitled "MEDICAL HISTORY QUESTIONNAIRE," which was completed by claimant on December 23, 2002. There is also a "PHYSICAL EXAMINATION" form, evidently completed by a registered nurse at Tyson on December 23, 2002.

However, in another Tyson document entitled "POST-OFFER HEALTH ASSESSMENT," completed by claimant and signed by both she and a registered nurse on April 12, 2010, claimant marked "no" to the following questions:

1. Have you been limited or restricted from work for health reasons?

2. Do you have any work restriction?

3. If yes, are restrictions permanent?

4. To the best of your knowledge do you have or have you been told that you have had any of the following?

. . .

23. Back Problems.

Another document in the Tyson material, consisting of two pages, is entitled "POST-OFFER HEALTH ASSESSMENT," and was signed on April 12, 2010, by the same registered nurse who signed the Health Questionnaire. The nurse who completed the form drew vertical lines on both pages indicating "YES" in all boxes listed on the form. The body parts listed are fingers, thumb, hands, elbow, shoulder, neck, knees, back and wrist. Underneath each body part are various techniques of physical examination. The Health Assessment states that if the boxes are marked "YES," then all aspects of the physical examination listed on the form were within normal limits. However, regarding the back there are no specifics set forth regarding the actual measurements of flexion, extension, Rt. Lateral Flexion, Lt. Lateral Flexion, Rt. Rotation, and Lt. Rotation. The Health Questionnaire likewise includes no specific measurements regarding the other parts of the body listed, with the exception of vision, hearing, and claimant's height, weight and vital

signs. The absence of any detailed findings regarding the back raises questions about the extent of the examination conducted by the nurse and whether there was any examination conducted at all.

The parties entered into another written stipulation, this one filed on August 27, 2012. The parties thereby agreed that certain documents from respondent be admitted into evidence. The documents, consisting of accident reports, investigation reports and a note of the plant nurse, all concern a right index finger injury sustained by claimant on May 1, 2009. These documents make no reference to back pain.

PRINCIPLES OF LAW

An employer is liable to pay compensation to an employee where the employee incurs personal injury by accident arising out of and in the course of employment.[22]

K.S.A. 2008 Supp. 44-501(a) states in part: "In proceedings under the workers compensation act, the burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends."

K.S.A. 2008 Supp. 44-508(g) defines burden of proof as follows: "'Burden of proof' means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record."

An injury arises out of employment if it arises out of the nature, conditions, obligations, and incidents of the employment.[23] Whether an accident arises out of and in the course of the worker's employment depends upon the particular facts of each claim.[24]

A recent Kansas Supreme Court opinion indicates:

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[22] K.S.A. 2008 Supp. 44-501(a).

[23] *Brobst v. Brighton Place North*, 24 Kan. App. 2d 766, 771, 955 P.2d 1315 (1997).

[24] *Springston v. IML Freight, Inc.*, 10 Kan. App. 2d 501, 704 P.2d 394, *rev. denied* 238 Kan. 878 (1985).

> Even though no bright-line test for whether an injury arises out of employment is possible, the focus of inquiry should be on the [sic] whether the activity that results in injury is connected to, or is inherent in, the performance of the job.[25]

K.S.A. 44-510e provides in relevant part:

> Permanent partial general disability exists when the employee is disabled in a manner which is partial in character and permanent in quality and which is not covered by the schedule in K.S.A. 44-510d and amendments thereto. The extent of permanent partial general disability shall be the extent, expressed as a percentage, to which the employee, in the opinion of the physician, has lost the ability to perform the work tasks that the employee performed in any substantial gainful employment during the fifteen-year period preceding the accident, averaged together with the difference between the average weekly wage the worker was earning at the time of the injury and the average weekly wage the worker is earning after the injury. In any event, the extent of permanent partial general disability shall not be less than the percentage of functional impairment. Functional impairment means the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein. An employee shall not be entitled to receive permanent partial general disability compensation in excess of the percentage of functional impairment as long as the employee is engaging in any work for wages equal to 90% or more of the average gross weekly wage that the employee was earning at the time of the injury.

ANALYSIS

The Board finds the ALJ erred in concluding claimant suffered any permanent injury or permanent functional impairment as a result of the April 15, 2009, accident. Although claimant did prove an injury, a thoracic sprain or strain, as a consequence of the April 2009 event, the preponderance of the credible evidence does not support the ALJ's conclusions that claimant suffered a permanent injury or that any permanent functional impairment resulted from the admitted accident.

The issue raised by respondent that claimant sustained no injury arising out of her employment requires no lengthy discussion. Claimant's testimony is undisputed that she experienced a burning in the middle of her back following the accident. There is no evidence of preexisting injury or disease which would have caused the symptoms in

[25] *Bryant v. Midwest Staff Solutions, Inc.*, 292 Kan. 585, 596, 257 P.3d 255 (2011).

claimant's thoracic spine. Claimant's symptoms worsened after the accident without any indication of intervening trauma.

Dr. Murati diagnosed thoracic spine strain secondary to the work injury. Dr. Do diagnosed thoracic sprain/strain and opined claimant's complaints related to April 15, 2009, accident. Although, as discussed in detail below, there are good reasons to question the reliability of the testimony of claimant, Drs. Murati and Do, the preponderance of the evidence established that claimant's accident resulted in an injury to the thoracic spine which arose out of her employment with respondent.

The more difficult issue is whether claimant proved her injury was permanent in nature and whether claimant proved that any permanent functional impairment resulted from the accident.

Dr. Murati's testimony lacks credibility for several reasons including:

1. Dr. Murati examined claimant only once, on May 18, 2010, before claimant was found to be at MMI by Dr. Do on August 8, 2011.

2. Dr. Murati apparently reviewed no medical records or reports either before or after he examined claimant. Dr. Murati did not reexamine claimant in the period after the May 2010 examination and his deposition on May 14, 2012, a period of almost two years.

3. The results of the diagnostic testing performed–either the reports of the testing or the actual films or other data–were not made available to Dr. Murati before or after his examination. Dr. Murati did not have x-rays taken as part of his evaluation.

4. Dr. Murati claimed his 5% rating was based on the AMA *Guides*' DRE Thoracolumbar Category II. However, Dr. Murati did not provide, either in his narrative report or in his deposition testimony, his rationale for placing claimant within Category II. Dr. Murati's findings on physical examination were lacking in any objective indication of injury. Dr. Murati also found "increased tone...in the mid-to [sic] lower thoracic paraspinals."[26] Dr. Murati did not explain what "increased tone" means in this context, but it is noteworthy that the doctor did not say muscle spasm or muscle guarding.

The Board also finds Dr. Do's testimony lacking in credibility. Dr. Do also concluded claimant sustained a 5% permanent loss of physical function based on DRE

[26] Murati Depo., Ex. 2 at 2.

Thoracolumbar Category II, for "myofascial type issues."[27] Dr. Do provided no explanation why myofascial pain would place claimant into Category II. Dr. Do imposed no permanent restrictions and found no task loss. Dr. Do admitted on cross-examination he could identify no objective findings he could relate to claimant's 2009 accident.[28]

The credibility of claimant's testimony has also been called into serious question. As examples:

1. The testimony of Mr. Briggs, the treating physician's assistant, found that claimant's complaints of pain were beyond one would expect from a thoracic sprain. Mr. Briggs found indications claimant was exaggerating her symptoms and was not being honest regarding her complaints. Mr. Briggs, Drs. Do and McMaster found no objective indications which were consistent with claimant's complaints.

2. Claimant testified that she did not improve from any of the treatment she received, which included various medications, physical therapy, and trigger point injections. Claimant also testified that her current level of pain is no better than it was on the day following the accident, when her pain was 7 to 9 on a 10-point scale.

3. Claimant underwent numerous diagnostic tests including plain x-rays; MRI scans of the left shoulder, thoracic spine, and lumbar spine; and a full body bone scan. All of the testing were negative.

4. The structural integrity of claimant's spine was normal and she was without any neurological compromise, despite her prolonged complaints.

5. As described in detail above, claimant was less than forthcoming about her post-injury employment for Tyson.

6. Claimant was less than candid in completing the Tyson employment forms.

The Board finds in this claim, the report and testimony of Dr. McMaster is the most credible medical evidence and it outweighs the testimony of claimant and the other medical witnesses. Dr. McMaster's diagnosis was transient non-specific, non-differentiated soft tissue pain. Dr. McMaster found no permanent injury and no permanent impairment of function resulting from the April 15, 2009 event. He imposed no permanent restrictions and found no task loss.

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[27] Do Depo., Ex. 2 at 2.

[28] *Id*. at 23.

Under the circumstances of this claim, the Board is compelled to find, although she did prove an injury, consisting of a thoracic sprain, claimant did not prove that her injury was permanent in nature, nor did she prove she sustained any permanent functional impairment resulting from the accidental injury. Accordingly, claimant is entitled to no PPD and the ALJ's Award is therefore reversed.

Claimant's right to future medical treatment will remain open upon proper application to and approval by the Director.

The contract entered into between claimant and his counsel is in the administrative file, but it is not file stamped. Claimant's counsel would need to file the contract with the ALJ and obtain approval from the judge of the contract and any attorneys fees sought.

The issue of claimant's entitlement to work disability is moot, given the Board's findings and conclusions.

CONCLUSIONS OF LAW

1. Claimant did prove she sustained personal injury, consisting of a thoracic sprain, arising out of her employment with respondent.

2. Claimant did not sustain her burden to prove she suffered a permanent injury as a result of the accident.

3. Claimant did not sustain her burden of proof that she sustained any permanent functional impairment as a result of the accidental injury.

4. Claimant's counsel is entitled to attorneys fees per his contract with claimant, assuming the contract is filed with the ALJ and the judge approves the contract and fees claimed.

5. Claimant is entitled to future medical compensation upon proper application to and approval by the Director.

As required by the Workers Compensation Act, all five members of the Board have considered the evidence and issues presented in this appeal.[29] Accordingly, the findings and conclusions set forth above reflect the majority's decision and the signatures below attest that this decision is that of the majority.

[29] K.S.A. 2008 Supp. 44-555c(k).

AWARD

WHEREFORE, the Board's decision that the Award of ALJ Pamela J. Fuller dated October 15, 2012, is reversed.

IT IS SO ORDERED.

Dated this _____ day of July, 2013.

_____
BOARD MEMBER

_____
BOARD MEMBER

_____
BOARD MEMBER

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